These charges are only allegations which may be contested by the licensee in an administrative hearing.

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

AYMAN SHAHINE, M.D.

STATEMENT

OF

CHARGES

AYMAN SHAHINE, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 8, 1993, by the issuance of license number 191635 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From on or about January 6, 2013 through on or about December 17, 2013, Respondent evaluated and treated Patient A, a then 65-year-old woman with 37-year-old breast implants, at his office at 1 West 34th Street, New York, New York, identified alternately under the titles NYBEAUTYSURGEON and NY Laser Cosmetic Center. Respondent deviated from the standard of care in that he exposed Patient A to grave risk as he:

1. On November 21, 2013, performed an extensive surgery involving the removal of Patient A's encapsulated implants and the placing of new saline implants, outside of a hospital operating room or approved office based surgery facility.
2. Failed to obtain pre-operative bloodwork for Patient A.
3. Failed to provide IV access and/or fluids during Patient A's surgery.
4. Failed to appropriately monitor Patient A's vital signs during the surgery.
5. Failed to document Patient A's blood loss as a result of the surgery.
6. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient A.

B. From on or about January 10, 2014 through on or about April 11, 2014, Respondent evaluated and treated Patient B, a then 5' 9", 212 pound 34-year-woman at his office at 1 West 34th Street, New York, New York. Respondent deviated from the standard of care in that he:

1. Failed to follow-up on a March 24, 2014 pre-operative blood result indicating that Patient B was in an early stage of pregnancy before proceeding to perform liposuction on April 11, 2014, on Patient B's abdomen, back and inner thighs with a fat transfer to her buttocks.
2. Failed to obtain a history and physical examination of Patient B at any time before the April 11, 2014 surgical procedure.
3. Failed to document in his operative report the amount of lidocaine-filled tumescent fluid he injected into Patient B.
4. Failed to document in his operative report the areas on which he surgically treated Patient B.
5. Falsely documented that he removed only 320 cc of subcutaneous fat combined from all the areas on which he surgically treated Patient B.
   a. Respondent did so with intent to deceive.
6. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient B.

C. From on or about March 27, 2014 through on or about June 25, 2014, Respondent evaluated and treated Patient C, a then 5' 11", 264 pound 53-year-woman at his office at 1 West 34th Street, New York, New York. Respondent deviated from the standard of care in that he:

1. Failed to document in his operative report the amount of lidocaine-filled tumescent fluid he injected into Patient C.
2. Failed to document in his operative report the areas on which he surgically treated Patient C.
3. Falsely documented that he removed only 460 cc of subcutaneous fat combined from all the areas on which he surgically treated Patient C.
   a. Respondent did so with intent to deceive.

4. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient C.

D. From on or about February 26, 2014 through on or about March 18, 2014, Respondent evaluated and treated Patient D, a then 5' 2", 143 pound 47-year-woman at his office at 1 West 34th Street, New York, New York. Respondent deviated from the standard of care in that he:

1. Failed to document in his operative report the amount of lidocaine-filled tumescent fluid he injected into Patient D.
2. Failed to document in his operative report the areas on which he surgically treated Patient D.
3. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient D.

E. From on or about September 27, 2002, when Patient E was 18 years-old, through on or about August 5, 2008, Respondent evaluated and treated her within his OB/GYN practice in Brooklyn, New York. Respondent deviated from the standard of care in that he:

1. Failed to obtain the results of Patient E's May 6, 2008 pap smear, which report on May 12, 2008 revealed normal findings, before performing a medically unnecessary colposcopy on Patient E on May 9, 2008.
2. Operated on Patient E, both in 2003 and 2004, at Lutheran Medical Center in Brooklyn, New York, for the removal of two respective ectopic pregnancies, yet despite this history, failed to obtain a urine test and/or order blood work to rule out pregnancy in Patient E on July 28, 2008, exposing her to great risk.
3. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient E.

F. From on or about August 30, 2010 through on or about January 7, 2011, Respondent evaluated and treated Patient F, a then 32-year-old woman, within

his OB/GYN practice in Brooklyn, New York. Respondent deviated from the standard of care in that he:

1. Failed to rule out pregnancy in Patient F on August 30, 2010, after Patient F reported a prior surgery for an ectopic pregnancy.
2. Ordered Clomid for Patient F on August 30, 2010 before ruling out pregnancy and/or indicating the reason he prescribed this medication.
3. Performed unnecessary and invasive urodynamic testing on Patient F on August 31, 2010, despite the absence of urologic complaints at her examination the day before, or in the alternative,
4. Documented that he performed such test on Patient F and billed for such service, but did not, in fact, perform the test.
   a. Respondent did so with intent to deceive.
5. Failed to follow-up on Patient F's alleged urologic complaints after the purported August 31, 2010 urodynamic testing.
6. Failed to rule out pregnancy in Patient F on January 7, 2011 by obtaining a urine test and/or ordering blood work, when she presented to Respondent with a chief complaint of a "missed period."
7. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient F.

G. From on or about February 27, 2011 through on or about April 28, 2011, Respondent evaluated and treated Patient G, a then 27-year-old woman, withir his OB/GYN practice in Brooklyn, New York. Respondent deviated from the standard of care in that he:

1. Performed unnecessary and invasive urodynamic testing on Patient G on April 28, 2011, when she was almost 10 weeks pregnant, despite the absence of urologic complaints at her examination the day before, or in the alternative,
2. Documented that he performed such test on Patient G and billed for such service, but did not, in fact, perform the test.
   a. Respondent did so with intent to deceive.

3. Failed to follow-up on Patient G's alleged urologic complaints after the purported April 28, 2011 urodynamic testing.
4. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient G.

H. From on or about October 7, 2011 through on or about December 16, 2011, Respondent evaluated and treated Patient H, a then 31-year-old woman, within his OB/GYN practice in Brooklyn, New York. Respondent deviated from the standard of care in that he:

1. Performed unnecessary and invasive urodynamic testing on Patient H on October 8, 2011, or in the alternative,
2. Documented that he performed such test on Patient H and billed for such service, but did not, in fact, perform the test.
   a. Respondent did so with intent to deceive.
3. Failed to follow-up on Patient H's alleged urologic complaints after the purported October 8, 2011 urodynamic testing.
4. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient H.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

1. Paragraph A and each of its subparagraphs.

2. Paragraph B and each of its subparagraphs, except 5 and 5(a).

3. Paragraphs E and E (1).

4. Paragraphs E and E (2).

5. Paragraph G, G (1), G (3) and G (4).

SIXTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

6. Paragraph A and each of its subparagraphs; Paragraph B and each of its subparagraphs, except 5 and 5(a); Paragraphs C, C (1), C (2) and C (4); Paragraph D and each of its subparagraphs; Paragraph E and each of its subparagraphs; Paragraph F and each of its subparagraphs, except 3 and 3(a); Paragraph G and each of its subparagraphs, except 2 and 2(a); and Paragraph H and each of its subparagraphs, except 2 and 2(a).

SEVENTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

7. Paragraph A and each of its subparagraphs, Paragraph B and each of its subparagraphs except 5 and 5(a), Paragraphs E, E (1) and E (2) and Paragraphs G and G (1).

EIGHTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

8. Paragraph A and each of its subparagraphs; Paragraph B and each of its subparagraphs, except 5 and 5(a); Paragraphs C, C (1), C (2) and C (4); Paragraph D and each of its subparagraphs; Paragraph E and each of its subparagraphs; Paragraph F and each of its subparagraphs, except 3 and 3(a); Paragraph G and each of its subparagraphs, except 2 and 2(a) and Paragraph H and each of its subparagraphs, except 2 and 2(a).

NINTH THROUGH ELEVENTH SPECIFICATIONS

UNWARRANTED TESTS/TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(35) by ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of:

9. Paragraphs F and F (3).

10. Paragraphs G and G (1)

11. Paragraphs H and H (1).

TWELFTH THROUGH SIXTEENTH SPECIFICATIONS

FRAUDULENT PRACTICE

12. Paragraphs B, B (5) and B(5)(a).

13. Paragraphs C, C (3) and C(3)(a).

14. Paragraphs F, F (4) and F(4)(a).

15. Paragraphs G, G (2) and G(2)(a).

16. Paragraphs H, H (2) and H(2)(a).

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

SEVENTEENTH THROUGH TWENTY-FIRST SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by willfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

17. Paragraphs B and B (5).

18. Paragraphs C and C (3).

19. Paragraphs F and F (4).

20. Paragraphs G and G (2).

21. Paragraphs H and H (2).

TWENTY-SECOND THROUGH TWENTY-NINTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

22. Paragraphs A and A (6).

23. Paragraphs B and B (6).

24. Paragraphs C and C (4).

25. Paragraphs D and D (3).

26. Paragraphs E and E (3).

27. Paragraphs F and F (7).

28. Paragraphs G and G (4).

29. Paragraphs H and H (4).

DATE: June 16, 2017
New York, New York

[redacted]

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct